Alabama Medicaid

Health Insurance Portability and Accountability Act (HIPAA)

837 Crossover Specifications for Vendors

Note: *The information in this document is subject to change. The use of this document is solely for the purpose of clarification. Please refer to the version number and effective date located in the footer of this document for the latest information available. A copy of the most current version of this companion document can be obtained from the internet at http://www.medicaid.state.al.us/HIPAA/index.htm.*

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1. Overview

The purpose of the 837 Crossover Reference guide is to communicate the fields in the 837 Professional and 837 Institutional HIPAA transactions necessary to successfully process crossover claims with Alabama Medicaid. The information provided in this document is to act as a guide when coding for crossover claims.

1.2 Audience

This document is written for the benefit of vendors who create software for providers that submit claims to the Alabama Medicaid Agency via electronic media.

2. 837 Professional Crossover

Loop	Segment	Data Element	Value
2000B	SBR – Subscriber Information	SBR01	S – Secondary (Medicaid) T – Tertiary (Medicaid) On crossover claims, Medicaid will either be listed as Secondary or Tertiary. If TPL is on the claim, then TPL is Primary, Medicare is Secondary and Medicaid would be Tertiary.
2320	SBR – Other Subscriber Information	SBR01	P – Primary (TPL or Medicare) S – Secondary (If TPL is present - Medicare)
		SBR05 (required)	MB – Medicare Part B If filing Medicare as Primary or Secondary, you must use MB.
		SBR09 (situational)	If used: MB – Medicare Part B
2320	CAS – Claim Level Adjustments	CAS01	PR – Patient Responsibility
		CAS02, CAS05	If known/used: 1 – Deductible Amount AND/OR 2 – Coinsurance Amount
2320	AMT – Coordination of Benefits (COB) Payer Paid Amount	AMT02	Header Medicare Paid Amount
2320	AMT – Coordination of Benefits (COB) Approved Amount	AMT02	Header Medicare Approved Amount

Loop	Segment	Data Element	Value
2320	AMT – Coordination of Benefits (COB) Allowed Amount	AMT02	Header Medicare Allowed Amount
2320	AMT – Coordination of Benefits (COB) Patient Responsibility Amount	AMT02	Header Patient Responsibility Amount of claim
2400	AMT – Approved Amount	AMT02	Detail Medicare Approved Amount
2430	SVD – Line Adjudication Information	SVD02	Detail Medicare Approved Amount
2430	CAS – Line Adjustment	CAS02, CAS05	If known/used: 1 – Deductible Amount AND/OR 2 – Coinsurance Amount
2430	DTP – Claim Pay Date	DTP03	Required if information in this loop has been populated.

3. 837 Institutional Crossover

3.1 Inpatient Crossover

Loop	Segment	Data Element	Value
2000B	SBR – Subscriber Information	SBR01	S – Secondary (Medicaid) T – Tertiary (Medicaid) On crossover claims, Medicaid will either be listed as Secondary or Tertiary. If TPL is on the claim, then TPL is Primary, Medicare is Secondary and Medicaid would be Tertiary.
2320	SBR – Other Subscriber Information	SBR01	P – Primary (TPL or Medicare) S – Secondary (If TPL is present - Medicare)
		SBR09	MA – Medicare Part A If filing Medicare as Primary or Secondary, you must use MA.
2320	CAS – Claim Level Adjustment	CAS02, CAS05	If known/used: 1 – Deductible Amount AND/OR 2 – Coinsurance Amount If the coinsurance amount is populated on the claim, then lifetime reserve days or coinsurance days must be submitted.
2320	AMT – Payer Prior Payment (Commercial Insurance)	AMT01	C4

Loop	Segment	Data Element	Value
2320	AMT – Payer Prior Payment (Commercial Insurance)	AMT02	Other Payer Paid Amount, TPL Amount (not Medicare)
2320	AMT – Coordination of Benefits (COB) Total Allowed Amount	AMT01	B6
2320	AMT – Coordination of Benefits (COB) Total Allowed Amount	AMT02	Medicare Allowed Amount
2320	AMT – Coordination of Benefits (COB) Total Submitted Charges	AMT01	T3
2320	AMT – Coordination of Benefits (COB) Total Submitted Charges	AMT02	Medicare Total Billed
2320	AMT – Coordination of Benefits (COB) Total Medicare Paid Amount	AMT01	N1
2320	AMT – Coordination of Benefits (COB) Total Medicare Paid Amount	AMT02	Medicare Paid Amount
2330B	DTP – Claim Adjudication Date	DTP03	TPL Paid Date AND/OR Medicare Paid Date
2330B	REF – Other Payer Secondary Identification and Reference Number	REF01	F8 – Original Reference Number
		REF02	If known: Medicare Internal Control Number (ICN)

3.2 Outpatient Crossover

Loop	Segment	Data Element	Value
2000B	SBR – Subscriber Information	SBR01	S – Secondary (Medicaid) T – Tertiary (Medicaid) On crossover claims, Medicaid will either be listed as Secondary or Tertiary. If TPL is on the claim, then TPL is Primary, Medicare is Secondary and Medicaid would be Tertiary.
2320	SBR – Other Subscriber Information	SBR01	P – Primary (TPL or Medicare) S – Secondary (If TPL is present - Medicare)
		SBR09	MB – Medicare Part B If filing Medicare as Primary or Secondary, you must use MB.
2320	CAS – Claim Level Adjustment	CAS02, CAS05	If known/used: 1 – Deductible Amount AND/OR 2 – Coinsurance Amount
2320	AMT – Payer Prior Payment (Commercial Insurance)	AMT01	C4
2320	AMT – Payer Prior Payment (Commercial Insurance)	AMT02	Other Payer Paid Amount, TPL Amount (not Medicare)
2320	AMT – Coordination of Benefits (COB) Total Allowed Amount	AMT01	B6
2320	AMT – Coordination of Benefits (COB) Total Allowed Amount	AMT02	Medicare Allowed Amount
2320	AMT – Coordination of Benefits (COB)	AMT01	T3

Loop	Segment	Data Element	Value
	Total Submitted Charges		
2320	AMT – Coordination of Benefits (COB) Total Submitted Charges	AMT02	Medicare Total Billed
2320	AMT – Coordination of Benefits (COB) Total Medicare Paid Amount	AMT01	N1
2320	AMT – Coordination of Benefits (COB) Total Medicare Paid Amount	AMT02	Medicare Paid Amount
2330B	DTP – Claim Adjudication Date	DTP03	TPL Paid Date AND/OR Medicare Paid Date
2330B	REF – Other Payer Secondary Identification and Reference Number	REF01	F8 – Original Reference Number
		REF02	If known: Medicare Internal Control Number (ICN)

3.3 Long Term Care Crossover

Loop	Segment	Data Element	Value
2000B	SBR – Subscriber Information	SBR01	S – Secondary (Medicaid) T – Tertiary (Medicaid) On crossover claims, Medicaid will either be listed as Secondary or Tertiary. If TPL is on the claim, then TPL is Primary, Medicare is Secondary and Medicaid would be Tertiary.
2300	QTY – Claim Quantity	QTY01	CD – Covered Days CA – Coinsurance Days
2320	SBR – Other Subscriber Information	SBR01	P – Primary (TPL or Medicare) S – Secondary (If TPL is present - Medicare)
		SBR09	MA – Medicare Part A If filing Medicare as Primary or Secondary, you must use MA.
2320	CAS – Claim Level Adjustment	CAS02	2 – Coinsurance Amount
2320	AMT – Payer Prior Payment (Commercial Insurance)	AMT01	C4
2320	AMT – Payer Prior Payment (Commercial Insurance)	AMT02	Other Payer Paid Amount, TPL Amount (not Medicare)
2320	AMT – Coordination of Benefits (COB) Total Allowed Amount	AMT01	B6
2320	AMT – Coordination of Benefits (COB) Total Allowed Amount	AMT02	Medicare Allowed Amount
2320	AMT – Coordination of Benefits (COB) Total Submitted Charges	AMT01	T3

Loop	Segment	Data Element	Value
2320	AMT – Coordination of Benefits (COB) Total Submitted Charges	AMT02	Medicare Total Billed
2320	AMT – Coordination of Benefits (COB) Total Medicare Paid Amount	AMT01	N1
2320	AMT – Coordination of Benefits (COB) Total Medicare Paid Amount	AMT02	Medicare Paid Amount
2330B	DTP – Claim Adjudication Date	DTP03	TPL Paid Date AND/OR Medicare Paid Date
2330B	REF – Other Payer Secondary Identification and Reference Number	REF01	F8 – Original Reference Number
		REF02	If known: Medicare Internal Control Number (ICN)

4. Current COB Processing

Header Claim level adjustment amounts submitted ?	Detail Claim level adjustment amounts submitted ?	Alabama Medicaid COB Processing
2320, AMT = AAE, Medicare Allowed Amount 2320, AMT = D, Medicare Paid Amount 2320, CAS = PR-2, Medicare Coinsurance Amount	2400, AMT = AAE, Medicare Allowed Amount 2430, SVD, Medicare Paid Amount 2430, CAS = PR-2, Medicare Coinsurance Amount	
NO	YES	The header values will be calculated for the claim submitted by Alabama Medicaid and balancing will be performed internally. The submitter is not required to submit the header values.
YES	YES	Balancing will be performed on the header and detail values submitted. If the detail submitted values do not equal the header submitted value, Alabama Medicaid will deny the claim. If the detail submitted values do equal the header submitted values, Alabama Medicaid will not deny the claim. If both header and detail values are submitted, balancing must occur on the values submitted.
YES	NO	Alabama Medicaid will deny the claim. Detail adjustment values must be submitted to successfully process a COB claim.